

Facility Name & ID Number METHODIST HOME# 0005439 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>23</u>	Skilled (SNF)	<u>23</u>	<u>8,418</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>98</u>	Intermediate (ICF)	<u>98</u>	<u>35,868</u>	3
4		Intermediate/DD			4
5	<u>12</u>	Sheltered Care (SC)	<u>12</u>	<u>4,392</u>	5
6		ICF/DD 16 or Less			6
7	<u>133</u>	TOTALS	<u>133</u>	<u>48,678</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>1,781</u>	<u>1,044</u>	<u>2,360</u>	<u>5,185</u>	8
9	SNF/PED					9
10	ICF	<u>16,084</u>	<u>15,037</u>		<u>31,121</u>	10
11	ICF/DD					11
12	SC		<u>1,646</u>		<u>1,646</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>17,865</u>	<u>17,727</u>	<u>2,360</u>	<u>37,952</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 77.97%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)Senior FitnessF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 1898

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 23 and days of care provided 2,360Medicare Intermediary AdminaStar

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number

METHODIST HOME

0005439

Report Period Beginning:

01/01/04

Ending:

12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	295,608	22,870	116,131	434,609		434,609		434,609		1
2	Food Purchase		236,130		236,130		236,130	(7,549)	228,581		2
3	Housekeeping	175,335	33,409		208,744		208,744	(12,000)	196,744		3
4	Laundry	41,715	10,095		51,810		51,810		51,810		4
5	Heat and Other Utilities			147,989	147,989		147,989		147,989		5
6	Maintenance	150,067	29,149	69,595	248,811		248,811	(6,360)	242,451		6
7	Other (specify):*										7
8	TOTAL General Services	662,725	331,653	333,715	1,328,093		1,328,093	(25,909)	1,302,184		8
	B. Health Care and Programs										
9	Medical Director			36,345	36,345		36,345		36,345		9
10	Nursing and Medical Records	2,022,790	141,690	13,363	2,177,843		2,177,843		2,177,843		10
10a	Therapy	57,624	1,488	9,142	68,254		68,254		68,254		10a
11	Activities	105,812	4,660	8,548	119,020		119,020		119,020		11
12	Social Services	48,129	2,285	21,354	71,768		71,768		71,768		12
13	Nurse Aide Training										13
14	Program Transportation			2,103	2,103		2,103		2,103		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,234,355	150,123	90,855	2,475,333		2,475,333		2,475,333		16
	C. General Administration										
17	Administrative	17,399			17,399		17,399	70,037	87,436		17
18	Directors Fees										18
19	Professional Services			120,486	120,486		120,486		120,486		19
20	Dues, Fees, Subscriptions & Promotions			64,610	64,610		64,610	(39,699)	24,911		20
21	Clerical & General Office Expenses	398,100	26,687	83,993	508,780		508,780	(59,273)	449,507		21
22	Employee Benefits & Payroll Taxes			604,602	604,602		604,602	3,327	607,929		22
23	Inservice Training & Education			503	503		503		503		23
24	Travel and Seminar			12,637	12,637		12,637	(8,136)	4,501		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			229,564	229,564		229,564		229,564		26
27	Other (specify):*										27
28	TOTAL General Administration	415,499	26,687	1,116,395	1,558,581		1,558,581	(33,744)	1,524,837		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,312,579	508,463	1,540,965	5,362,007		5,362,007	(59,653)	5,302,354		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number **METHODIST HOME**

#0005439

Report Period Beginning:

01/01/04

Ending:

12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			248,910	248,910		248,910		248,910			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			48,231	48,231		48,231	(48,231)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			10,021	10,021		10,021		10,021			35
36	Other (specify):*											36
37	TOTAL Ownership			307,162	307,162		307,162	(48,231)	258,931			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		321,413	276,674	598,087		598,087		598,087			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			66,430	66,430		66,430		66,430			42
43	Other (specify):* Marketing/HRA D	43,961		11,250	55,211		55,211	(55,211)				43
44	TOTAL Special Cost Centers	43,961	321,413	354,354	719,728		719,728	(55,211)	664,517			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,356,540	829,876	2,202,481	6,388,897		6,388,897	(163,095)	6,225,802			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number METHODIST HOME

0005439

Report Period Beginning: 01/01/04

Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(7,549)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,580)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(48,231)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(11,373)	21		24
25	Fund Raising, Advertising and Promotional	(15,105)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(24,594)	20		28
29	Other-Attach Schedule	(125,027)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (236,459)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (236,459)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

METHODIST HOME

ID# 0005439

Report Period Beginning: 01/01/04

Ending: 12/31/04

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Winwood Revenue - Maintenance	\$ (6,360)	6	1
2	Winwood Revenue - Housekeeping	(12,000)	3	2
3	Winwood Revenue - Management	(18,972)	21	3
4	Miscellaneous Income	(4,423)	21	4
5	Marketing	(43,961)	43	5
6	Marketing	(19,925)	21	6
7	Non Allowable Seminar Costs	(6,722)	24	7
8	Health Resources Alliance Dues	(11,250)	43	8
9	Travel - Marketing	(1,414)	24	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(125,027)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number METHODIST HOME# 0005439

Report Period Beginning:

01/01/04

Ending:

12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(7,549)	0	0	0	0	0	0	0	0	0	0	(7,549)	2
3	Housekeeping	(12,000)	0	0	0	0	0	0	0	0	0	0	(12,000)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(6,360)	0	0	0	0	0	0	0	0	0	0	(6,360)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(25,909)	0	0	0	0	0	0	0	0	0	0	(25,909)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	70,037	0	0	0	0	0	0	0	0	0	70,037	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(39,699)	0	0	0	0	0	0	0	0	0	0	(39,699)	20
21	Clerical & General Office Expenses	(59,273)	0	0	0	0	0	0	0	0	0	0	(59,273)	21
22	Employee Benefits & Payroll Taxes	0	3,327	0	0	0	0	0	0	0	0	0	3,327	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(8,136)	0	0	0	0	0	0	0	0	0	0	(8,136)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(107,108)	73,364	0	0	0	0	0	0	0	0	0	(33,744)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(133,017)	73,364	0	0	0	0	0	0	0	0	0	(59,653)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number **METHODIST HOME**# **0005439**

Report Period Beginning:

01/01/04

Ending:

12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(48,231)	0	0	0	0	0	0	0	0	0	0	(48,231)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(48,231)	0	0	0	0	0	0	0	0	0	0	(48,231)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(55,211)	0	0	0	0	0	0	0	0	0	0	(55,211)	43
44	TOTAL Special Cost Centers	(55,211)	0	0	0	0	0	0	0	0	0	0	(55,211)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(236,459)	73,364	0	0	0	0	0	0	0	0	0	(163,095)	45

Facility Name & ID Number **METHODIST HOME**# **0005439**

Report Period Beginning:

01/01/04

Ending:

12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
UNITED METHODIST HOMES & SERVICES	100 %			NAPER VALLEY CO	CHICAGO	INACTIVE
				UMH&S FOUNDATION	CHICAGO	FOUNDATION
				WINWOOD APARTMENTS	CHICAGO	ELDERLY HOUSING

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	0	UNITED METHODIST HOMES & SERVICES FOUNDATION	100.00%	\$ 70,037	\$ 70,037	1
2	V		Administrator - Allocated Salary Expense					2
3	V	22	0	UNITED METHODIST HOMES & SERVICES FOUNDATION	100.00%	3,327	3,327	3
4	V		Administrator - Allocated FICA Expense					4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$ 73,364	\$ * 73,364	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number METHODIST HOME # 0005439 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number METHODIST HOME # 0005439 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization UMH&S FOUNDATION
 Street Address 1415 W. FOSTER AVE.
 City / State / Zip Code CHICAGO, IL 60640
 Phone Number (773) 769-5500
 Fax Number (773) 769-6287

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	Administrator Salary	12	10	\$ 84,044	\$ 84,044	10	\$ 70,037	1
2	22	Administrator FICA	12	10	3,992	0	10	3,327	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 88,036	\$ 84,044		\$ 73,364	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related Long-Term																		
1	Bonds		X	Refinance Buildings & Renovations		07/20/98	\$ 1,225,761	\$ 1,225,761	07/20/23	Various	\$ 33,536	1							
2												2							
3												3							
4												4							
5							Interest Income Offset (to the extent of expense)					(48,231)	5						
	Working Capital																		
6	Harris Bank		X	Working Capital		Various	300,000	300,622			14,695	6							
7												7							
8												8							
9	TOTAL Facility Related						\$ 1,525,761	\$ 1,526,383					\$	9					
	B. Non-Facility Related*																		
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$					\$	14					
15	TOTALS (line 9+line14)						\$ 1,525,761	\$ 1,526,383					\$	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **METHODIST HOME**# **0005439** Report Period Beginning: **01/01/04** Ending: **12/31/04****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1. Real Estate Tax accrual used on 2003 report.			\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1999		8	
	2000		9	
	2001		10	
	2002		11	
	2003		12	
FOR OHF USE ONLY				
	13	FROM R. E. TAX STATEMENT FOR 2003	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
N/A - Facility is not subject to real estate taxes	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

FACILITY NAME	METHODIST HOME	COUNTY	COOK
---------------	----------------	--------	------

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE () FAX #: ()

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

68,281

B. General Construction Type:

Exterior

BRICK

Frame

CONCRETE BLOCK

Number of Stories

5

C. Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

Related business entities are identified on page 6, Schedule VII - Related Parties. Specific facilities located adjacent to The Methodist Home are:

Winwood Apartments, Inc. - 1406 W. Winona - a 31 unit HUD subsidized apartment building for very low income adults.

Glenwood Apartments - 5027 N. Glenwood - a 13 unit apartment complex for very low income adults.

Foster Apartments - 1433 W. Foster - 2 flat - intergenerational housing.

Wellness Center Building - 1355 W. Foster - contains offices of United Methodist Homes & Services and UMH&S Foundation as well as rental space for White Crane Wellness Center.

The costs for these entities are segregated and not included as part of the financial information presented on this report for The Methodist Home.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	HEALTH CARE	39,375	1898-1950	\$ 25,000	1
2					2
3	TOTALS	39,375		\$ 25,000	3

Facility Name & ID Number **METHODIST HOME**# **0005439**

Report Period Beginning:

01/01/04

Ending:

12/31/04**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	42			1922	\$ 214,000	\$		\$	\$	\$ 214,000	4
5	48			1951	297,000					297,000	5
6				1972	941,207					941,207	6
7	8			1973	541,942					541,942	7
8	35			1974	479,275					479,275	8
	Improvement Type**										
9		ELEVATOR; HEATING AND A/C SYSTEM		1975	898,240		25			898,240	9
10		BEAUTY SHOP AND SWIFT OFFICE		1976	1,203		20			1,203	10
11		NURSING OFFICE AND CONFERENCE ROOM PARTITION		1980	1,300		20			1,300	11
12		DINING AND BOILER ROOM		1983	215		20			215	12
13		DOOR ALARMS		1984	1,188	29	20	29		1,188	13
14		SIDEWALK; PAVEMENT		1985	7,958	397	20	397		7,758	14
15		FENCING		1986	31,965	1,598	20	1,598		29,567	15
16		SIDEWALK		1987	3,680	184	20	184		3,220	16
17		ROOF & LIGHTING		1988	41,556		10			41,556	17
18		PARKING LOT		1989	123,634		10			123,634	18
19		GROUND FLOOR BATHROOMS AND BEAUTY SHOP		1990	81,482		10			81,555	19
20		1ST FLOOR COMMON AREAS		1991	155,195		10			154,296	20
21		1ST FLOOR ROOM RENOVATIONS 7 2ND FLOOR NURSING STAT		1992	224,277		10			219,394	21
22		LIVING ROOM & 2ND FLOOR HALLWAYS		1993	211,680		10			205,150	22
23		3RD FLOOR RENOVATIONS & 4TH FLOOR NURSES STATION		1994	239,782	11,737	10	11,737		233,003	23
24		4TH FLOOR RENOVATIONS & ADMINISTRATIVE OFFICES		1995	143,955	14,374	10	14,374		136,549	24
25		REPLACE CHILLER (AIR CONDITIONING SYSTEM)		1996	264,240	15,658	10	15,658		133,090	25
26		3RD FLOOR RENOVATIONS & SEWER LINE		1997	50,445	6,943	10	6,943		36,848	26
27		NURSING STATION - 2ND FL, DOOR ALARM SYSTEM - 4TH FL, CH		1998	70,774	7,056	10	7,056		45,864	27
28		AUTOMATIC DOOR - LOBBY, 4TH FLOOR - TILE & RENOVATION		1999	33,593	2,998	10	2,998		16,489	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

STATE OF ILLINOIS

Page 12A

Facility Name & ID Number **METHODIST HOME**# **0005439**

Report Period Beginning:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Improvement Type**	2 Year Constructed	3 Cost	4 Current Book Depreciation	5 Life in Years	6 Straight Line Depreciation	7 Adjustments	8 Accumulated Depreciation	9
37			\$	\$		\$	\$	\$	37
38	Carpeting 1988 - 1992		52,134		5			52,134	38
39	Carpeting	1993	14,437		5			14,437	39
40	Carpeting	1994	21,507		5			21,507	40
41	Carpeting	1995	18,800		5			18,800	41
42	Carpeting	1996	17,235		5			17,235	42
43	Carpeting	1997	5,198		5			5,198	43
44	Carpeting	1998	39,439		5			39,439	44
45	Carpeting	1999	531	54	5	54		531	45
46									46
47	Main Stairway Upgrade, Plumbing, Remodeling of Resident Rooms - Floor	2000	76,700	7,670	10	7,670		34,515	47
48	Main Elevator Upgrade	2000	38,713	1,936	20	1,936		8,712	48
49	Air Conditioner - Circulation Pump Replacement	2000	787	31	25	31		140	49
50	Carpeting - 4th Floor, Main Stairway, Rooms - 57, 70, 74	2000	12,458	2,492	5	2,492		11,214	50
51	Parking Lot Improvements - Concrete Replacement, Trees, Fence	2000	7,596	760	10	760		3,420	51
52									52
53	1st Floor Nursing Station Remodeling, Flooring - 2nd Fl Dining Ro	2001	81,554	8,155	10	8,155		28,543	53
54	Heat & A/C - Multistack A/C Unit, Chiller Condensor Bypass Filte	2001	13,647	546	25	546		1,911	54
55	Carpeting - Rms, 55, 75, 79, LL Corridor, 1st Fl Conf. Room	2001	6,120	1,224	5	1,224		4,284	55
56									56
57	Fire Alarm System, 2nd Fl Nursing Station & Dining Room Remod	2002	235,781	23,578	10	23,578		58,945	57
58	Main Elevator Upgrade	2002	4,965	248	20	248		620	58
59	Carpeting - Resident Services Office, Rm 48, Front Entrance	2002	2,656	531	5	531		1,328	59
60	Parking Lot Improvements - Seal Coating	2002	2,375	238	10	238		595	60
61									61
62	Magnetic Door System, Renovation-Senior Fit Area, Resident Room	2003	199,523	19,952	10	19,952		29,928	62
63	Carpeting - Resident Rooms 64, 80, Res. Svc Office, Adm. Office	2003	1,349	270	5	270		405	63
64	Lighting Retro Fit, Sewage Ejector Pumps, Emergency Generator I	2003	29,290	1,465	20	1,465		2,197	64
65									65
66	Resident Room Remodeling, Magnetic Door System, 4th Fl Nursing	2004	50,774	2,540	10	2,540		2,540	66
67	Ejector Pump - Rehab Office, Fire Dampers, Drain for Wash Mach	2004	4,854	121	20	121		121	67
68	Stairway Ramp Renovation - Parking Lot	2004	3,224	161	10	161		161	68
69	Carpeting - Main Lobby, 1st Floor, 3rd Floor	2004	25,194	2,519	5	2,519		2,519	69
70	TOTAL (lines 4 thru 69)		\$ 6,026,627	\$ 135,465		\$ 135,465	\$	\$ 5,204,928	70

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,135,456	\$ 97,330	\$ 97,330	\$		\$ 689,697	71
72	Current Year Purchases	50,311	2,515	2,515			2,515	72
73	Fully Depreciated Assets	581,964					581,964	73
74								74
75	TOTALS	\$ 1,767,731	\$ 99,845	\$ 99,845	\$		\$ 1,274,176	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	PATIENT TRANSPORTATION	FORD BUS, 2002	2001	\$ 54,399	\$ 13,600	\$ 13,600	\$		\$ 45,368	76
77										77
78										78
79										79
80	TOTALS			\$ 54,399	\$ 13,600	\$ 13,600	\$		\$ 45,368	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 7,873,757	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 248,910	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 248,910	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,524,472	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: **N/A**

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ **10,021** Description: **Copiers - Leased**

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. **/2005** \$

13. **/2006** \$

14. **/2007** \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** **This amount plus any amortization of lease expense must agree with page 4, line 34.**

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L39,C3	hrs	\$	2,025	\$ 105,228	\$	2,025	\$ 105,228	1
2	Licensed Speech and Language Development Therapist	L39,C3	hrs		30	3,902		30	3,902	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L39,C3	hrs		2,243	121,344		2,243	121,344	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39,C2	# of prescrpts				290,022		290,022	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Med Suppl, Lab, X-Ray	L39,C2,C3				46,200	31,391		77,591	13
14	TOTAL			\$	4,298	\$ 276,674	\$ 321,413	4,298	\$ 598,087	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 274,882	\$	1
2	Cash-Patient Deposits	58,308		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 137,388)	306,310		3
4	Supply Inventory (priced at)	18,329		4
5	Short-Term Investments			5
6	Prepaid Insurance	86,354		6
7	Other Prepaid Expenses	3,652		7
8	Accounts Receivable (owners or related parties)	1,557,518		8
9	Other(specify): <u>A/R - Misc Receivables</u>	614		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,305,967	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	225,982		12
13	Land	25,000		13
14	Buildings, at Historical Cost	6,026,627		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,822,130		16
17	Accumulated Depreciation (book methods)	(6,524,472)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Unamortized Financing Costs</u>	22,021		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,597,288	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,903,255	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 94,740	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	97,808		28
29	Short-Term Notes Payable	349,622		29
30	Accrued Salaries Payable	315,460		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	2,279		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Unexpended Restricted Gifts</u>	41,208		36
37	<u>Due to Third-Party Payor</u>	39,625		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 940,742	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	1,176,761		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,176,761	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,117,503	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,785,752	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,903,255	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,750,583	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,750,583	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(264,831)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (264,831)	17
	B. Transfers (Itemize):		
18	Equity Transfer from UMH&S Foundation	300,000	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 300,000	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,785,752	24 *

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,065,906	1
2	Discounts and Allowances for all Levels	(1,070,212)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,995,694	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	466,798	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 466,798	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	7,549	14
15	Telephone, Television and Radio	4,580	15
16	Rental of Facility Space		16
17	Sale of Drugs	324,078	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,611	19
20	Radiology and X-Ray	2,406	20
21	Other Medical Services	148,964	21
22	Laundry	14,561	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 510,749	23
	D. Non-Operating Revenue		
24	Contributions	30,171	24
25	Interest and Other Investment Income***	68,582	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 98,753	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	WW Apts Revenue (Adjusted Out - Page 5)	37,332	28
28a	Other - See attached Schedule	14,740	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 52,072	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,124,066	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,328,093	31
32	Health Care	2,475,333	32
33	General Administration	1,558,581	33
	B. Capital Expense		
34	Ownership	307,162	34
	C. Ancillary Expense		
35	Special Cost Centers	653,298	35
36	Provider Participation Fee	66,430	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,388,897	40
41	Income before Income Taxes (line 30 minus line 40)**	(264,831)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (264,831)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **METHODIST HOME**# **0005439**Report Period Beginning: **01/01/04**

Ending:

12/31/04**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,628	2,022	\$ 58,104	\$ 28.74	1
2	Assistant Director of Nursing	1,280	1,399	38,426	27.47	2
3	Registered Nurses	27,641	29,487	758,149	25.71	3
4	Licensed Practical Nurses	11,128	11,963	251,911	21.06	4
5	Nurse Aides & Orderlies	86,326	91,122	883,933	9.70	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,573	4,155	57,624	13.87	8
9	Activity Director	1,116	1,255	32,614	25.99	9
10	Activity Assistants	6,133	6,448	73,198	11.35	10
11	Social Service Workers	2,652	2,826	48,129	17.03	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	3,993	4,359	51,242	11.76	14
15	Cook Helpers/Assistants	18,910	20,297	180,817	8.91	15
16	Dishwashers	7,765	8,008	63,549	7.94	16
17	Maintenance Workers	6,642	7,416	150,067	20.24	17
18	Housekeepers	18,970	19,994	175,335	8.77	18
19	Laundry	4,725	4,849	41,715	8.60	19
20	Administrator	392	526	17,399	33.08	20
21	Assistant Administrator					21
22	Other Administrative	19,259	21,319	398,100	18.67	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,959	2,111	32,153	15.23	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Suppl Sched.</u>	1,345	1,477	44,075	29.84	33
34	TOTAL (lines 1 - 33)	225,437	241,033	\$ 3,356,540 *	\$ 13.93	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	520	36,345	L9C3	36
37	Medical Records Consultant	96	4,128	L10,C3	37
38	Nurse Consultant	139	8,340	L10,C3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	208	2,600	L11,C3	44
45	Social Service Consultant	44	2,310	L12,C3	45
46	Other(specify) <u>Rehab Consulting</u>	201	9,142	L10A,C3	46
47	<u>Dietary Management Fees</u>	Monthly	110,024	L1,C3	47
48	<u>Senior Fit Consultant</u>	1,104	37,128	L39,C3	48
49	TOTAL (lines 35 - 48)	2,312	\$ 210,017		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount			
David Randle	Administrator		\$ 17,399	Workers' Compensation Insurance	\$ 56,765	IDPH License Fee	\$			
Larry Loecker -	Administrator			Unemployment Compensation Insurance	83,615	Advertising: Employee Recruitment	1,900			
(Allocation on p6 & p8)				FICA Taxes	259,096	Health Care Worker Background Check	1,000			
				Employee Health Insurance	201,985	(Indicate # of checks performed 178)				
				Employee Meals		Books & Subscriptions	9,645			
				Illinois Municipal Retirement Fund (IMRF)*		Membership Fees	10,837			
				Employee Recognition	6,468	Resident Relations	1,529			
						Advertising	39,699			

* Attach copy of IMRF notifications

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. Life Services of IL - \$5,432
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 71,756 Line L10,C2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 66,430
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? YES Indicate the amount. \$ 7,549
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100% of L14.
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: FROST, RUTTENBERG & ROTHBLATT, P.C. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.